DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Coordinated Care Network
Dental Benefits Plan
(LAC 50:I.Chapter 29)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:Chapter 29 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions which implemented a coordinated system of care in the Medicaid Program designed to improve quality of care and health care outcomes through a healthcare delivery system called coordinated care networks, also known as the BAYOU HEALTH Program (*Louisiana Register*, Volume 37, Number 6).

The department now proposes to adopt provisions governing Medicaid coordinated care in order to establish a dental benefits plan through a coordinated care network for all Medicaid recipients under 21 years of age covered in BAYOU HEALTH [the Louisiana Medicaid Program]. This action is being taken to promote the public health and welfare of Medicaid recipients by ensuring continued access to better coordinated and quality dental care services. It is estimated that implementation of this Emergency Rule will be cost neutral to the Medicaid Program for state fiscal year 2012-2013.

Effective January 1, 2013, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing Medicaid coordinated care to establish a dental benefits plan through a coordinated care network.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Medicaid Coordinated Care
Chapter 29. Coordinated Care Network Dental Benefits Plan

§2901. General Provisions

A. Effective March 1, 2013, the Department of Health and Hospitals, Bureau of Health Services Financing shall implement a dental benefits plan through a coordinated care network to provide dental services to recipients under 21 years of age.

B. A coordinated care network dental benefit plan (CCN-DBP) shall serve Medicaid fee-for-service (FFS), BAYOU HEALTH Shared Savings Plan and BAYOU HEALTH Prepaid Health Plans members.

C. Exclusion. The following individuals shall be excluded from enrollment in the CCN-DBP and will continue to receive dental services through the FFS program when appropriate:

1. individuals who are 21 years of age and older; and
2. individuals who reside in out-of-state facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2903. Participation Requirements

A. In order to participate in the Medicaid Program, a CCN-DBP must be a successful bidder, be awarded a contract with the department, and complete the readiness review.

B. A CCN-DBP must:

1. meet the federal definition of a PAHP (Prepaid Ambulatory Health Plan) as defined in 42 CFR §438;
2. meet the requirements of R.S. 22:2016 and be licensed, or have a certificate of authority from the Louisiana Department of Insurance (DOI) pursuant to Title 22 of the Louisiana Revised Statues;
3. be certified by the Louisiana Secretary of State to conduct business in the state;
4. meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes;
5. have a network capacity to enroll a minimum of 627,000 Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) eligibles into the network; and
6. not have an actual or perceived conflict of interest that, at the discretion of the department, would interfere or give the appearance of possibly interfering with its duties and obligations under this Rule, the contract and any and all appropriate guides.
    a. Conflict of interest shall include, but is not limited to, being the fiscal intermediary contractor for the department.

C. A CCN-DBP shall ensure the provision of core benefits and services to all assigned members on the day the BAYOU HEALTH DBP is implemented.

D. Upon request by the Centers for Medicare and Medicaid Services, the Office of Inspector General, the Government Accounting Office, the department or its designee, a CCN-DBP shall make all of its records pertaining to its contract (services provided there under and payment for services) with the department available for review, evaluation and audit. The records shall include, but are not limited to the following:

1. pertinent books and documents;
2. financial records;
3. medical records and documents; and
4. provider records and documents involving financial transactions related to the contract.

E. A CCN-DBP shall maintain an automated management information system that collects, analyzes, integrates, and reports data that complies with department and federal reporting requirements.

1. The CCN-DBP shall submit to the department for approval the CCN-DBP's emergency/contingency plan if the CCN-DBP is unable to provide the data reporting specified in the contract and department-issued guides.

F. A CCN-DBP shall obtain insurance coverage(s) as specified in the terms of the contract. Subcontractors, if any, shall be covered under these policies or have insurance comparable to the CCN-DBP's required coverage.

G. A CCN-DBP shall provide all financial reporting as specified in the terms of the contract.

H. A CCN-DBP shall secure and maintain a performance and fidelity bond as specified in the terms of the contract during the life of the contract.

I. In the event of noncompliance with the contract and the department's guidelines, a CCN-DBP shall be subject to the sanctions specified in the terms of the contract including, but not limited to:

1. corrective action plans;
2. monetary penalties;
3. temporary management; or
4. suspension and/or termination of the CCN-DBP's contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2905. Managed Care Organization Model Responsibilities

A. The CCN-DBP shall be responsible for the administration and management of its requirements and responsibilities under the contract with the department and any and all department issued guides. This includes all subcontracts, employees, agents and anyone acting for or on behalf of the CCN-DBP.

1. No subcontract or delegation of responsibility shall terminate the legal obligation of the CCN-DBP to the department to assure that all requirements are carried out.

B. A CCN-DBP shall possess the expertise and resources to ensure the delivery of core benefits and services to members and to assist in the coordination of covered services, as specified in the terms of the contract.

1. A CCN-DBP shall have written policies and procedures governing its operation as specified in the contract and department-issued guides.

C. A CCN-DBP shall accept enrollees in the order in which they apply without restriction.

1. A CCN-DBP shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status, or need for health care services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

D. A CCN-DBP shall be required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered services consistent with standards as defined in the Louisiana Medicaid State Plan and as specified in the terms of the contract.

E. The CCN-DBP shall establish and implement a quality assessment and performance improvement program as specified in the terms of the contract and department issued guides.

G. A CCN-DBP shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract and department issued guides.

H. The CCN-DBP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

1. The CCN-DBP shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid programs as well all requirements set forth in the contract and department-issued guides.

I. A CCN-DBP shall maintain a health information system that collects, analyzes, integrates, and reports data as specified in the terms of the contract and all department-issued guides.

1. A CCN-DBP shall collect data on enrollees and provider characteristics and on services furnished to members through an encounter data system as specified in the contract and all department-issued guides.

J. A CCN-DBP shall be responsible for conducting routine provider monitoring to ensure continued access to care for Medicaid recipients and compliance with departmental and contract requirements.

K. A CCN-DBP shall not engage the services of a provider who is in non-payment status with the department or is excluded from participation in federal health care programs (i.e., Medicare, Medicaid, CHIP, etc.).

L. Medical records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

M. The CCN-DBP shall provide both member and provider services in accordance with the terms of the contract and department-issued guides.

1. The CCN-DBP shall submit member handbooks, provider manuals, and a provider directory to the department for approval prior to distribution, annually and subsequent to any revisions.

a. The CCN-DBP must provide a minimum of 30 days notice to the department of any proposed material changes to the member handbooks and/or provider manuals.

b. After approval has been received from the department, the CCN-DBP must provide a minimum of 15 days notice to the members and/or providers of any proposed material changes to the member handbooks and/or provider manuals.

N. The member handbook shall include, but not be limited to:

1. a table of contents;
2. a general description regarding:
   a. how a coordinated care network operates;
   b. member rights and responsibilities;
   c. appropriate utilization of services; and
   d. the provider selection process;

3. member rights and protections as specified in 42 CFR §438.100 and the CCN-DBP's contract with the department including, but not limited to:

a. a member's right to change providers within the CCN-DBP;

b. any restrictions on the member's freedom of choice among CCN-DBP providers; and

c. a member's right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the CCN-DBP if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;

4. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CCN-DBP or the department including, but not limited to:

a. reporting to the department's Medicaid Customer Service Unit if the member has or obtains another health insurance policy, including employer sponsored insurance; and

5. the amount, duration, and scope of benefits available under the CCN-DBP's contract with the department in sufficient detail to ensure that members

understand the benefits to which they are entitled including, but not limited to:

a. information about oral health education and promotion programs;

b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

c. how members may obtain benefits, including emergency services, from out-of-network providers;

d. how and where to access any benefits that are available under the Louisiana Medicaid State Plan, but are not covered under the CCN-DBP's contract with the department;

e. the policy on referrals for specialty care;

f. how to make, change, and cancel dental appointments and the importance of canceling and/or rescheduling rather than being a "no show"; and

g. the extent to which and how after-hour services are provided;

6. information to call the Medicaid Customer Service Unit toll free telephone number or visit a local Medicaid eligibility office to report changes in parish of residence, mailing address, or family size changes;

7. a description of the CCN-DBP's member services and the toll-free telephone number, fax number, e-mail address, and mailing address to contact CCN-DBP's Member Services Unit;

8. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English, Spanish, and Vietnamese; and

9. grievance, appeal and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and the CCN-DBP's contract with the department.

O. The provider manual shall include but not be limited to:

1. billing guidelines;

2. medical management/utilization review guidelines;

3. case management guidelines;

4. claims processing guidelines and edits;

5. grievance and appeals procedures and processes; and

6. other policies, procedures, guidelines, or manuals containing pertinent information related to operations and pre-processing claims.

P. The provider directory for members shall be developed in three formats:

1. a hard copy directory for members and, only upon request, potential members; and

2. a web-based online directory for members and the public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2907. Network Access Standards and Guidelines

A. The CCN-DBP must maintain and monitor a provider network that is supported by written agreements and is sufficient to provide adequate access of healthcare to enrollees as required by federal law and the terms as set forth in the contract. The CCN-DBP shall adhere to the federal regulations governing access standards as well as the specific requirements of the contract and all department-issued guides.

B. The CCN-DBP must provide for service delivery out-of-network for any core benefit or service not available in network for which the CCN-DBP does not have an executed contract for the provision of such medically necessary services. Further, the CCN-DBP must arrange for payment so that the Medicaid enrollee is not billed for this service.

C. The CCN-DBP shall cover all medically necessary services to treat an emergency dental condition in the same amount, duration, and scope as stipulated in the Medicaid State Plan.

1. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b. serious impairment to bodily functions; or

c. serious dysfunction of any bodily organ or part.

2. Emergency services means covered outpatient services that are as follows:

a. furnished by a provider that is qualified to furnish these services under this Section; and

b. needed to evaluate or stabilize an emergency medical condition.

D. The CCN-DBPP must maintain a provider network and in-area referral providers in sufficient numbers, as determined by the department, to ensure that all of the required core benefits and services are available and accessible in a timely manner within the CCN-DBP's designated geographic service area(s) as approved by the department, in accordance with the terms and conditions in the contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2909. Benefits and Services

A. Core benefits and services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to enrollees under the Louisiana Medicaid State Plan.

1. Core benefits and services shall be defined as those oral health care services and benefits required to be provided to Medicaid CCN members Medicaid Fee-For-Service System as specified under the terms of the contract.

2. Covered services shall be defined as those health care services and benefits to which a Medicaid eligible individual is entitled to under the Louisiana Medicaid State Plan.

B. The CCN-DBP:

1. shall ensure that medically necessary services, defined in LAC 50:I.1101, are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished;

2. may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;

3. may place appropriate limits on a service:

a. on the basis of certain criteria, such as medical necessity; or

b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

4. shall provide core benefits and services as outlined and defined in the contract and shall provide medically necessary and appropriate care to Medicaid eligible members;

5. shall provide all of the core benefits and services consistent with, and in accordance with, the standards as defined in the Title XIX Louisiana Medicaid State Plan:

a. the CCN-DBP may exceed the limits as specified in the minimum service requirements outlined in the contract;

b. no medical service limitation can be more restrictive than those that currently exist under the Title XIX Louisiana Medicaid State Plan; and

C. If the CCN-DBP elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the CCN-DBP must furnish information about the services it does not cover in accordance with §1932(b)(3)(B)(ii) of the Social Security Act and federal regulations by notifying:

1. the department in its response to the department's request for proposals (RFP) or whenever it adopts the policy during the term of the contract;

2. the potential enrollees before and during enrollment in the CCN-DBP;

3. enrollees within 90 days after adopting the policy with respect to any particular service; and

4. members through the inclusion of the information in the member handbook.

D. The following is a summary listing of the core benefits and services that a CCN-DBP is required to provide:

1. diagnostic services which include oral examinations, radiographs and oral/facial images, diagnostic casts and accession of tissue – gross and microscopic examinations;

2. preventive services which include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers and re-cementation of space maintainers;

3. restorative services which include amalgam restorations, composite restorations, stainless steel and polycarbonate crowns, stainless steel crowns with resin window; pins, core build-ups, pre-fabricated posts and cores, resin-based composite restorations, appliance removal, and unspecified restorative procedures;

4. endodontic services which include pulp capping, pulpotomy, endodontic therapy on primary and permanent teeth (including treatment plan, clinical procedures and follow-up care), apexification/recalcification, apicoectomy/periradicular services and unspecified endodontic proceduresorgan transplant-related services;

5. periodontal services which include gingivectomy, periodontal scaling and root planning, full mouth debridement, and unspecified periodontal procedures;

6. removable prosthodontics services which include complete dentures, partial dentures, denture repairs, denture relines and unspecified prosthodontics procedures;

7. maxillofacial prosthetic services which include fluoride gel carrier;

8. fixed prosthodontic services which include fixed partial denture pontic, fixed partial denture retainer and other unspecified fixed partial denture services;

9. oral and maxillofacial surgery services which include non-surgical extractions, surgical extractions, coronal remnants extractions, other surgical procedures, alveoloplasty, surgical incision, temporomandibular joint (TMJ) procedure and other unspecified repair procedures, durable medical equipment and certain supplies;

10. orthodontic services which include interceptive and comprehensive orthodontic treatments, minor treatment to control harmful habits and other orthodontic services; and;

11. adjunctive general services which include palliative (emergency) treatment, anesthesia, professional visits, miscellaneous services, and unspecified adjunctive procedures.

NOTE: The list of services in §2909.D.1-11 is not all inclusive. The contract, policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, published fee schedules, and guides issued by the department are the final authority regarding services.

E. The core benefits and services provided to the members shall include, but are not limited to, those services specified in the contract.

1. Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

G. Excluded Services

1. The CCN-DBP is not obligated to provide for the services that are not specified in the contract. Covered services not listed in the contract will continue to be reimbursed by the CCN-P and/or Medicaid Program on a fee-for-service basis. The CCN-DBP shall provide any appropriate medical documentation and/or referral that is medically necessary. The department shall have the right to incorporate these services at a later date if the per member, per month (PMPM) rates have been adjusted to incorporate the cost of such service.

H. Utilization Management

1. The CCN-DBP shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review. The program shall include service authorization and medical necessity review and comply with the requirements set forth in this Section and the contract.

a. The CCN-DBP shall submit UM policies and procedures to the department for written approval, annually and subsequent to any revisions.

2. The UM Program policies and procedures shall, at a minimum, include the following requirements:

a. the individual(s) who is responsible for determining medical necessity, appropriateness of care, level of care needed, and denying a service authorization request or authorizing a service in amount, duration or scope that is less than requested, must meet the following requirements. The individual shall:

i. be a licensed clinical professional with appropriate clinical expertise in the treatment of a member's condition or disease;

ii. have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending such action by any hospital, governmental agency or unit, or regulatory body, that raise a substantial question as to the clinical peer

reviewer's physical, mental, or professional competence or moral character; and

iii. attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise;

b. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

c. the data sources and clinical review criteria used in decision making;

d. the appropriateness of clinical review shall be fully documented;

e. the process for conducting informal reconsiderations for adverse determinations;

f. mechanisms to ensure consistent application of review criteria and compatible decisions;

g. data collection processes and analytical methods used in assessing utilization of healthcare services; and

h. provisions for assuring confidentiality of clinical and proprietary information.

3. The UM program's medical management and medical necessity review criteria and practice guidelines shall be reviewed annually and updated periodically as appropriate. The CCN-DBP shall use the medical necessity definition as set forth in LAC 50:I.1101 for medical necessity determinations.

a. Medical management and medical necessity review criteria and practice guidelines shall:

i. be objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

ii. consider the needs of the members;

iii. be adopted in consultation with contracting health care professionals; and

iv. be disseminated to all affected providers, members, and potential members upon request.

b. The CCN-DBP must identify the source of the medical management criteria used for the review of medical necessity and for service authorization requests.

i. The vendor must be identified if the criteria are purchased.

ii. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society.

iii. The guideline source must be identified if the criteria are based on national best practice guidelines.

iv. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN-DBP dental director or other qualified and trained professionals.

4. The CCN-DBP shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

5. The CCN-DBP shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2911. Payment Methodology

A. Payments to the Dental Benefit Plan. The department, or its fiscal intermediary, shall make monthly capitation payments to the dental benefit plan (DBP) based on a per member, per month (PMPM) rate.

B. As Medicaid is the payor of last resort, the DBP must agree to accept the PMPM rate as payment-in-full from the department and agree not to seek additional payment from a member for any unpaid cost.

C. A DBP shall assume 100 percent liability for any expenditure above the prepaid premium.

D. A DBP shall meet all financial reporting requirements specified in the terms of the contract.

E. A DBP shall have a medical loss ratio (MLR) for each MLR reporting calendar year of not less than 85 percent using definitions for health care services, quality initiatives and administrative cost as specified in 45 CFR Part 158.

1. A DBP shall provide an annual MLR report, in a format as determined by the department, by June 1 following the MLR reporting year that separately reports the DBP's medical loss ratio for services provided to Medicaid enrollees and payment received under the contract with the department from any other products the DBP may offer in the state of Louisiana.

2. If the medical loss ratio is less than 85 percent, the DBP will be subject to refund of the difference, within the timeframe specified, to the department by August 1. The portion of any refund due the department that has not been paid by August 1 will be subject to interest in the amount of ten percent per annum.

3. The department shall provide for an audit of the DBP's annual MLR report and make public the results within 60 calendar days of finalization of the audit.

F. Any cost sharing imposed on Medicaid members must be in accordance with the federal regulations governing cost sharing and cannot exceed the amounts reflected in the Louisiana Medicaid State Plan, but the amounts can be less than the cost sharing levels in the State Plan.

G. The department may adjust the PMPM rate, during the term of the contract, based on:

1. the inclusion of covered Medicaid services not incorporated in the applicable PMPM;

2. the implementation of federal requirements; and/or

3. legislative appropriations and budgetary constraints.

H. The DBP shall not assign its rights to receive the PMPM payment, or it obligation to pay, to any other entity.

1. At its option, the department may, at the request of the DBP, make payment to a third party administrator.

I. In the event that an incorrect payment is made to the DBP, all parties agree that reconciliation will occur.

1. If an error or overcharge is discovered by the department, it will be handled in accordance with the terms and conditions of the contract.

J. Network Provider Reimbursement

1. Reimbursement for covered services shall be equal to or greater than the published Medicaid fee-for-service rate in effect on the date of service. Notwithstanding, upon request by a network provider, or potential network provider,

and with the prior approval of the department, exceptions may be granted.

2. The DBP's subcontract with the network provider shall specify that the provider shall accept payment made by the DBP as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from the department or the member.

a. The term "member" shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served.

3. The DBP may enter into alternative payment arrangements with its network providers or potential providers with prior approval by the department.

a. The DBP shall not enter into alternative payment arrangements with federally qualified health centers or rural health clinics as the DBP is required to reimburse these providers according to the published FQHC/RHC Medicaid prospective payment schedule rate in effect on the date of service, whichever is applicable.

K. Out-of-Network Provider Reimbursement. The DBP shall reimburse the provider the published Medicaid fee-for-service rate in effect on the date of service.

M. Reimbursement for Emergency Services for In-Network or Out-of-Network Providers

1. The DBP is financially responsible for emergency services in accordance with provisions set forth in 42 CFR §422.113.

2. The reimbursement rate for medically necessary emergency services shall be no less than the published Medicaid fee-for-service rate in effect on the date of service, regardless of whether the provider that furnished the services has a contract with the DBP.

a. The DBP may not concurrently or retrospectively reduce a provider's reimbursement rate for these emergency services provided during an episode of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2913. Prompt Payment of Claims

A. Network Providers. All subcontracts executed by the CCN-DBP shall comply with the terms in the contract. Requirements shall include at a minimum:

1. the name and address of the official payee to whom payment shall be made;

2. the full disclosure of the method and amount of compensation or other consideration to be received from the CCN-DBP; and

3. the standards for the receipt and processing of claims as specified by the department in the CCN-DBP's contract with the department and department issued-guides.

B. Network and Out-of-Network Providers

1. The CCN-DBP shall make payments to its network providers, and out-of-network providers, subject to conditions outlined in the contract and department issued-guides.

a. The CCN-DBP shall pay 90 percent of all clean claims, as defined by the department, received from each provider type within 15 business days of the date of receipt.

b. The CCN-DBP shall pay 99 percent of all clean claims within 30 calendar days of the date of receipt.

2. The provider must submit all claims for payment no later than 12 months from the date of service.

3. The CCN-DBP and all providers shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws.

a. Any such documents shall be retained for a period of at least six years or until the final resolution of all litigation, claims, financial management reviews, or audits pertaining to the contract.

4. There shall not be any restrictions on the right of the state and federal government to conduct inspections and/or audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of costs.

C. Claims Management

1. The CCN-DBP shall process a provider's claims for covered services provided to members in compliance with all applicable state and federal laws, rules, and regulations as well as all applicable CCN policies and procedures including, but not limited to:

a. claims format requirements;

b. claims processing methodology requirements;

c. explanation of benefits and related function requirements;

d. processing of payment errors;

e. notification to providers requirements; and

f. timely filing.

D. Provider Claims Dispute

1. The CCN-DBP shall:

a. have an internal claims dispute procedure that is in compliance with the contract and must be approved by the department;

b. contract with independent reviewers to review disputed claims;

c. systematically capture the status and resolution of all claim disputes as well as all associate documentation; and

d. report the status of all disputes and their resolution to the department on a monthly basis as specified in the contract.

E. Claims Payment Accuracy Report

1. The CCN-DBP shall submit an audited claims payment accuracy percentage report to the department on a monthly basis as specified in the contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2915. Grievance and Appeals Processes

A. The CCN-DBP shall adhere to the provisions governing the grievance and appeals processes for coordinated care network prepaid models outlined in LAC 50:I.Chapter 37, Subparts B and C.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2917. Sanctions

A. The CCN-DBP shall adhere to the provisions governing sanctions for coordinated care networks outlined in LAC 50:I.Chapter 39.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

§2919. Audit Requirements

A. The CCN-DBP shall adhere to the provisions governing audit requirements for coordinated care networks outlined in LAC 50:I.Chapter 40.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein
Secretary

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